

Date Re-Assessment Started: _____

Assessing Practitioner (Name and Discipline): _____

Date of client's Full Assessment to be used as the baseline for this Re-Assessment: _____

Date of client's most recent Re-Assessment (if applicable): _____

Other Sources for Re-Assessment Information: _____

Purpose:

- ☐ Tri-Annual
☐ Returning to Treatment

Reason for Referral/Chief Complaint

Describe precipitating event(s)/Reason for Referral:

- ☐ Tri-Annual – same as Full Assessment ☐ Returning to Treatment – updates include the following: (describe below)

Current Symptoms and Behaviors (intensity, duration, onset, frequency) and Impairments in Life Functioning caused by the symptoms/behaviors (from perspective of client and others):

Client Strengths (to assist in achieving treatment goals such as athletics, clubs, affiliations, social, personal, relations)

History of Presenting Problem

History of Presenting Problem Prior to Precipitating Event: Include how it is a problem, caregiver perception of cause, relevant factors (environment, relationships, traumatic events, sleep patterns, eating patterns, hygiene changes)

- ☐ Tri-Annual – same as Full Assessment ☐ Returning to Treatment – updates include the following: (describe below)

Additional Problem Areas and Associated Behaviors: Peer Problems and Other Problems

- ☐ Tri-Annual – same as Full Assessment ☐ Returning to Treatment – updates include the following: (describe below)

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Los Angeles County – Department of Mental Health

Mental Health History

Psychiatric Hospitalizations:

☐ No Updates ☐ Updates include the following: (describe below)

Outpatient Treatment:

Medications

Medications (Name, dosage, frequency, period taken, effectiveness, response, side-effects, reactions)

☐ See Medication Note dated _____ ☐ Updates include the following: (describe below)

Substance Use/Abuse

Substance Use and Abuse

☐ No Updates ☐ Updates include the following: (describe below)
(If applicable: Completed COD Assessment dated _____)

Medical History

Medical History

Date of Last Physical Exam: _____

☐ No Updates ☐ Updates include the following: (describe below)

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Developmental Milestones (Describe if not within normal limits)		Environmental Stressors Moves; schools; losses of fam/friends, changes in fam composition; SES, lifestyle; exposure to fam conflict/violence; major illnesses; abuse; placements, etc.
Infancy (0-3) Motor – sit, crawl, walk Speech; Eat; Sleep Toilet training Coordination Temperament Separation	<input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)	Infancy (0-3)
Early Years (4-6) Social Adjustment Separation Sexual Behaviors Self-Care	<input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)	Early Years (4-6)
Latency (7-11) School adjustment Peer & adult relations/friends Interest/hobbies Impulse control Self-Care	<input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)	Latency (7-11)
Adolescence (12-on) Separation/individ. Sexual orientation Sexual behavior Gender identity Relationships/Support Systems Independent funct. Moral development	<input type="checkbox"/> No Updates <input type="checkbox"/> Updates include the following:(describe below)	Adolescence (12-on)

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Psychosocial History

School History

Educational Comments: Type of School, Academic Performance, Grade Retention, School Changes, Attitude/Behavior, Attendance/Truancy, Suspension

☐ No Updates ☐ Updates include the following: (describe below)

Vocational Information (jobs, independent living program, training, job related problems, volunteer work, career interests)

☐ No Updates ☐ Updates include the following: (describe below)

Juvenile Court History (arrests/offenses, tickets/warnings, probation/stipulations, incarceration, placement)

☐ No Updates ☐ Updates include the following: (describe below)

Child Abuse and Protective Services Information (nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services)

☐ No Updates ☐ Updates include the following: (describe below)

Current Living Situation

Living Situation Type: ☐ Biological ☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Others Diagnosed with Mental Illness in Living Situation: ☐ Yes ☐ No

Significant Current Drug/Alcohol Use in Living Situation: ☐ Yes ☐ No

Family Composition (Include siblings, stepparents/others, grandparents, extended family, ethnicity/culture, education, socio-economic, religious affiliation)

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Mental Status	
<p>Appearance Dress, grooming, unusual physical characteristics</p> <p>Behavior Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity</p> <p>Expressive Speech Fluency, pressure, impediment, volume</p> <p>Thought Content Fears, worries, preoccupations, obsessions, delusions, hallucinations</p> <p>Thought Process Attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g. planning)</p> <p>Cognition Orientation, vocabulary, abstraction, intelligence</p> <p>Mood/Affect Depression, agitation, anxiety, hostility absent or unvarying, irritability</p> <p>Suicidality/Homicidality Thoughts, behavior, stated intent, risks to self or others. access to lethal means</p> <p>Attitude/Insight/Strengths Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment.</p>	<p>Provide a word picture of this child based on your observations. Be sure to address relevant features from each bolded category in the left column.</p>

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Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

II. Diagnosis (check one Principle and one Secondary)

Axis I ☐ Prin ☐ Sec Code _____ Nomenclature _____

(Medications cannot be prescribed with a deferred diagnosis)

☐ Sec Code _____ Nomenclature _____

Code _____ Nomenclature _____

Code _____ Nomenclature _____

Code _____ Nomenclature _____

Axis II ☐ Prin ☐ Sec Code _____ Nomenclature _____

☐ Sec Code _____ Nomenclature _____

Code _____ Nomenclature _____

Axis III _____ Code _____

_____ Code _____

_____ Code _____

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

Primary Problem #: ____

Check as many that apply:

- | | | | |
|--|---|---|---|
| 1. <input type="checkbox"/> Primary support group | 2. <input type="checkbox"/> Social environment | 3. <input type="checkbox"/> Educational | 4. <input type="checkbox"/> Occupational |
| 5. <input type="checkbox"/> Housing | 6. <input type="checkbox"/> Economics | 7. <input type="checkbox"/> Access to health care | 8. <input type="checkbox"/> Involve w/Legal Sys |
| 9. <input type="checkbox"/> Other psychosocial/environmental | 10. <input type="checkbox"/> Inadequate information | | |

Axis V Current GAF: _____ DMH Dual Diagnosis Code: _____

III. Specialty Mental Health Services Medical Necessity Criteria:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Medi-Cal Specialty Mental Health Included Diagnosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Significant impairment in life functioning due to the Included Diagnosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Expectation that proposed interventions can impact the client's condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Condition will not be responsive to physical health care based treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

IV. Disposition/Recommendations/Plan

V. Signatures

Assessor's Signature & Discipline

Date

Co-Signature & Discipline

Date

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